



# MEDICAL CARE PLAN

GIFFORD MEDICAL CENTER  
RANDOLPH, VERMONT 05060

<b>Name:</b>	<b>Nick Name:</b>	<b>DOB:</b>
<b>Allergies:</b>	<b>Complexity:</b>	
<b>Parent/Guardian:</b>	<b>Phone #:</b>	
<b>PCP:</b>	<b>Insurance:</b>	
<b>PCP Phone #:</b>	<b>Parent Emergency #:</b>	

<b>Special Instructions:</b>

<i>Unique Family Needs/Assets:</i>

<i>Antibiotic Prophylaxis:</i>	<i>Indications:</i>	<i>Medication &amp; Dose:</i>
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PROBLEM LIST	MED Y / N	SPECIALIST INVOLVED	OUTCOME	HOW OFTEN	LAST VISIT
Health Maintenance					

( ★ ) - See Med Sheet in Chart

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# MEDICAL CARE PLAN



Patient Name:

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PROCEDURES	TESTS	LABS	LAST DONE	VALUE

## Other Services:

TYPE OF SERVICE	SERVICE GIVEN BY	FREQUENCY

DEVICES	DATE STARTED

## \*\*Unique Immunization Needs:

Influenza									
Pneumococcal									
RSV									
Other									

(\* \*) For full record see chart.

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## List of Health Care and Other Service Providers

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Dx:1 \_\_\_\_\_ Dx2 \_\_\_\_\_ Dx3 \_\_\_\_\_

Health Care:	Name/Location	Phone #	Fax #	Referral Date
Specialists:				
Special clinics: (coordinators)				
Other:				

School Services:	Name/Location	Phone #	Fax #	Effective Dates
Early intervention:				
School attending:				
School principal(s):				
Classroom teacher(s):				
School nurse(s):				
Spec. ed. coordinator:				
Other personnel:				

Community services:	Name/Location	Phone #	Fax #
Family support coordinator:			
Visiting nurse:			
Mental health provider:			
HMO/Insurance contact:			
DCYF case worker:			
Other service providers:			
Informal supports: minister, friend, etc.)			



# CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE



## Care Planning

Parent's Names \_\_\_\_\_ / \_\_\_\_\_

Child's Name \_\_\_\_\_ Diagnosis(s) \_\_\_\_\_

Phones(H) \_\_\_\_\_ / \_\_\_\_\_ (W) \_\_\_\_\_ / \_\_\_\_\_

Best Time / Place To Call \_\_\_\_\_ FAX # if available \_\_\_\_\_

CCM Monitoring: Questioning & Interventions in the following areas:

Date:				
Family's #1 Issue				
Health Provider's #1 Issue				
Chronic Condition Update (meds, acute episodes, etc.)				
Child's Life/ Recent Accomplishments:				
Family Life				
Comm/Family Support Issues				
Financial Issues (insurance, SSI, etc.)				
School Needs				
Specialist Contacts				
Patient Education/ Self Care				
Other				

PARENT NOTEBOOK GIVEN (DATE) \_\_\_\_\_ OFFICE CONTACT PERSON \_\_\_\_\_





## CHRONIC CONDITION MANAGEMENT (CCM) IN PRIMARY CARE NEXT STEPS NEEDED

Child's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Diagnosis(s) \_\_\_\_\_

Date	Task	Who	Notes	Date Done

Next appointment needed/Next CCM monitoring visit:

Date Care Plan Last Revised:        /        /        /        /        /        /        /        /



[illegible]

## Hitchcock Clinic—Concord Pediatric Care Plan Part I

Child's Name_____		Nickname_____		DOB_____	
Parent (Caregiver)_____			(Relationship)_____		
Address_____					
Phone #(home)_____		(Blocked? Y__N__)		Best time to reach_____	
E-mail_____					
Mom Alternate Phone_____			Dad Alternate Phone_____		
Emergency Contact_____			Phone _____		Relationship_____
Emergency Contact_____			Phone_____		Relationship_____
Health Insurance/Plan_____			Identification #_____		

**Diagnose(s):** ☐ Emergency Plan    ☐ Yes    ☐ No    **Complexity Level**\_\_\_\_\_

Primary _____	ICD9 _____	Primary _____	ICD9 _____
Secondary _____	ICD9 _____	Secondary _____	ICD9 _____
Secondary _____	ICD9 _____	Secondary _____	ICD9 _____

<b>Allergies/reaction:</b> _____ _____ _____ <b>Medications/dose:</b> _____ _____ _____ _____	
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PCP _____	Phone _____	Fax _____	E-Mail _____
#1 Specialist/Specialty    Clinic/Hospital    Phone	Other (fax, e-mail, etc.):		
#2	Other (fax, e-mail, etc.):		
#3	Other (fax, e-mail, etc.):		
#4	Other (fax, e-mail, etc.):		

**Nursing Service/Respite**\_\_\_\_\_ **Phone** \_\_\_\_\_

# SPECIALIZED EMERGENCY INFORMATION

## Hitchcock Clinic- Concord

Child's Name:

Nickname:

Date:

### Common Presenting Problems/Findings with Specific Suggested Managements

( ) *See specialist letter(s) attached*

**Problem #1**

**Presenting Signs & Symptoms**

Suggested Diagnostic Studies:

Treatment Considerations:

**Problem #2**

**Presenting Signs & Symptoms**

Suggested Diagnostic Studies:

Treatment Considerations:

**Problem #3**

**Presenting Signs & Symptoms**

Suggested Diagnostic Studies:

Treatment Considerations:

Comments on child, family, or other specific medical issues:

X

**Physician/Provider Signature**

**Print Name above**

X

**Family/guardian *signature* giving consent for release of this information to the emergency room**

**Print Name above**

## Care Plan Part II: Child Description

Name \_\_\_\_\_ Nickname \_\_\_\_\_ DOB \_\_\_\_\_

Child's Assets & Strengths \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Vital Sign (baselines)

Ht \_\_\_\_\_ Wt \_\_\_\_\_ Temp \_\_\_\_\_ Other \_\_\_\_\_

### Challenges (check all that apply, please explain on lines below)

☐ Behavioral

☐ Learning

☐ Stamina/Fatigue

☐ Communication

☐ Orthopedic/Musculoskeletal

☐ Respiratory

☐ Feed & Swallowing

☐ Physical Anomalies

☐ Other \_\_\_\_\_

☐ Hearing/Vision

☐ Sensory

☐ Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Procedures/foods/activities to be avoided:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Prior surgeries/procedures:

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Date \_\_\_\_\_

### Most recent labs/diagnostic studies:

Labs

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug levels

\_\_\_\_\_

\_\_\_\_\_

MRI/CT

\_\_\_\_\_

EEG

\_\_\_\_\_

EKG

\_\_\_\_\_

X-rays

\_\_\_\_\_

C-Spine

\_\_\_\_\_

Other

\_\_\_\_\_

Other

\_\_\_\_\_

## Care Plan Part II: Child Description

### Equipment/appliances/assistive Technology

Please check all that apply and use the lines below to explain:

- |                                       |   |                                     |
|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Gastrostomy  | <input type="checkbox"/> Adaptive Seating             | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Communication Device         | <input type="checkbox"/> Orthotics  |
| <input type="checkbox"/> Suction      | <input type="checkbox"/> Monitors: ( ) ___Apnea ___O2 | <input type="checkbox"/> Crutches   |
| <input type="checkbox"/> Nebulizer    | ___Cardiac___Glucose                                  | <input type="checkbox"/> Walker     |
|                                       |   | <input type="checkbox"/> Other_____ |

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**School System/Child Care:**

**Contact Person/Role:**

**Phone:**

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### Family Information:

Caregivers \_\_\_\_\_

Siblings \_\_\_\_\_

Other important facts \_\_\_\_\_

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### Special Circumstances/Comment/What you would like us to know

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\_\_\_\_\_  
Parent /Caregiver Signature & Date

\_\_\_\_\_  
Primary Care Provider Signature & Date

MEDICAL SUMMARY - EPIC-IC PA

Date updated _____	
Patient Name _____	DOB _____
Parent's Name _____	Phone(H) _____ (W) _____
Address _____	E-mail _____
Other Emergency Contact _____ Phone _____ Relationship _____ Insurance _____	
Principal Diagnosis _____	PCP _____
Secondary Diagnosis _____	PCP Phone _____
PCP Fax/E-mail _____	

Emergency Plan Yes _____ No _____ Immunizations up-to-date Yes _____ No _____ Date _____
Allergies/Rxns (meds/foods/procedures) _____

Problem List (with critical equipment)	

Medications / Dose	Medications / Dose

Specialists	Phone Number/Fax/E-mail

Equipment/Transport Information

History
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Review of Systems & general/baseline physical/lab data	
HEENT (vision/hearing)	Musculoskeletal
CV	Skin
Respiratory	Neuro
GI	Psych
Hem	Endo
GU	Immune

Coverage Concerns/Recurrent Presenting Problems	Diagnostic Studies	Treatment
Problem		

#### Support Services

Service	Frequency	Contact Information
Home Care		
PT/OT		
DME		
School/Child Care/EI		
Other		

Hospitalizations/Surgery	Date	Procedures